Claims Clues

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QMB Update

1st Payment Cycle to Run in January

The first payment cycle for QMB Only claims submitted to the AHCCCS Administration is scheduled to be run on Jan. 14, 2000.

AHCCCS began processing fee-for-service QMB Only claims on Oct. 1. Prior to Oct. 1, providers were required to send QMB only claims to the TPA.

QMB only recipients are not eligible for AHCCCS but are eligible for reimbursement of coinsurance and deductible for Medicare-covered services.

Providers with questions about QMB Only claims should call (602) 417-7940.

AHCCCS also is initiating an automated crossover process for fee-for-service claims from providers whose Medicare carrier or intermediary is BlueCross/ BlueShield of North Dakota, BlueCross/BlueShield of Arizona, and BlueCross/Blue-Shield of Texas (Trailblazers).

Here are some guidelines for providers to follow:

QMB Only Claims

Until further notice, providers should send QMB only fee-for-service claims to:

AHCCCS Administration
Attn: Lori Petre
P.O. Box 25520
Phoenix, AZ 85002

Providers should write "QMB Only Claims" on the envelope and include the Medicare EOMB with the claim.

The Medicare coinsurance and deductible, if applicable, must be entered in Field 24K of the HCFA 1500 claim form. Enter coinsurance first and the deductible as the second figure.

Coinsurance and deductible must be entered in Field 41 of the UB-92 claim form with the appropriate value codes. Use value code A1 to indicate Part A deductible and A2 for Part A coinsurance, if applicable.

Providers must enter their AHCCCS provider ID and 2-digit locator code in the "PIN#" section of Field 33 of the HCFA 1500. A facility's AHCCCS provider ID number must be entered in Field 51 of the UB-92.

Beginning with claims submitted to Medicare in January, if a provider does not receive payment from AHCCCS within 60 days of being reimbursed by Medicare, the provider should call the Claims Customer Service Unit at (602) 417-7670 (Option 4) to check on the status of the claim.

Medicare Crossover

Beginning in January, when a provider submits a claim to Medicare for an AHCCCS-eligible recipient, the claim will automatically be crossed over to AHCCCS when Medicare issues reimbursement. Providers no longer are required to submit claims to AHCCCS for paid Medicare claims for AHCCCS recipients.

If Medicare denies the claim or if the claim is adjusted, a claim must be submitted to AHCCCS. These claims must comply with the claim submission requirements described previously, including submission of the Medicare or Medicare HMO EOMB.

When submitting a HCFA 1500 claim for a Medicare HMO member, the charges in Field 24F must be the provider's billed charges, not the co-pay amount. The co-pay must be entered in Field 24K as coinsurance with a zero entered as the deductible.

All Medicare crossover claims will be identified on the provider's remittance advice. ❐

Last Claims Cycle for 1999 To Run Dec. 29

The last fee-for-service claims cycle for the year will be run on Dec. 29, 1999.

Reimbursement checks will be dated Dec. 31, 1999, and mailed on Jan. 3, 2000. ❐

Coding Corner

The AHCCCS Administration has made the following changes to its Reference subsystem:

Provider type 52 (MH clinic)
- A0100
- Add A0110 and W2050 effective 10/01/98.
- End date W2040 effective 01/31/00.

Provider type 72 (RBHA)
- End date W2040 effective 01/31/00.

Provider type 74 (Alternative residential facility)
- A0100
- Add A0110 and W2050 effective 10/01/98
- End date W2040 effective 01/31/00.

Provider type 77 (MH rehabilitation)
- A0100
- Add A0110 and W2050 effective 10/01/98.
- End date W2040 effective 01/31/00. ❐

Telephone Verification System Enhanced

The Interactive Voice Response (IVR) eligibility and enrollment verification system has been upgraded in order to reduce the time required to complete the verification process.

The most common last names in the AHCCCS recipient files have been recorded. When a provider uses IVR, the system will state the recipient's last name instead of spelling it back to the provider. This change is expected to help speed up the IVR process.

The IVR system allows an unlimited number of eligibility and enrollment verifications by entering information on a touch-tone telephone and following recorded instructions.

The IVR numbers are:

(602) 417-7200 (Phoenix area)

1-800-331-5090 (all others). ❐

Same Day Admit/Discharge Reimbursement Clarified

The AHCCCS Administration has clarified the reimbursement policy for same day admit/discharge hospital claims billed as an inpatient admission.

If the hospital bills the same day admit/discharge claim as an inpatient admission and the AHCCCS system would qualify the claim at the Maternity or Nursery tier, reimbursement will be the *lesser* of:
- All covered charges multiplied by the hospital-specific outpatient cost-to-charge ratio, or
- The per diem for the Maternity or Nursery classified tier.

Page 19-6 in Chapter 19 of the *AHCCCS Fee-For-Service Provider Manual* **incorrectly** states that reimbursement will be the lesser of all covered *ancillary* charges multiplied by the hospital-specific outpatient cost-to-charge ratio or the per diem for the Maternity or Nursery classified tier.

Providers should note this change in their manuals. ❐

Provider Asked to Follow Claim Submission Guidelines

To enable the AHCCCS Claims Control Unit to process claims as efficiently as possible, providers are asked to follow these guidelines when submitting paper claims to the AHCCCS Administration:
- Providers should "burst" HCFA 1500 claim forms when the forms are printed on continuous feed paper. They should not be submitted with pages joined at the perforations.
- If one page of an EOMB applies to claims for multiple recipients, providers must submit a separate copy of the EOMB with each claim. AHCCCS images the copy of the EOMB along with the claim.
- Providers must not submit multiple-page claims that have been copied on both sides of the paper. Each page must be on a separate piece of paper and numbered (e.g., 1 of 3, 2 of 3, 3 of 3). Pages should be paper clipped together in the upper left-hand corner. Providers should not staple the pages. ❐